# K A N S A S

RODERICK L. BREMBY, SECRETARY _____ KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Attention:   Human Resource Manager

Regarding:   Employment Verifications
             First Notice December 30, 2004

To comply with federal regulation 42 C.F.R. 483.156(b)(3), the Bureau of Health Facility Regulation, the Health Occupations Credentialing Unit (HOC) is required to determine whether certified nurse aides have had a lapse of employment of more than 24 consecutive months.

Effective January 1998, employment verification reporting is required on an annual basis. The reporting process will continue to be coordinated through Health Occupations Credentialing.

It is to the advantage of each facility to provide the employment verification information for each **Certified Nurse Aide/Home Health Aide/Medication Aide** employed for at least 8 hours during the last 12 months (January 1, 2004, through December 31, 2004).  Please list only the aides that are certified.  Students who are in Nurse Aide Trainee II status should not be included on the report.

Employment verifications are **due in this office by March 1, 2005.**

Reports with only partial information will be returned for completion.  Computer print outs will be accepted as long as they are readable and provide all the requested information.  If the print is too small, or the format is not easy to read, the report will be returned.

Be sure you include your Facility ID number (KDHE state ID) on your report.  If your report includes more than one facility, please include the Facility ID number for **each** facility and specify which names belong with each facility.

Thank you for your cooperation.  If you have any questions, please contact Janell McMillan at (785) 296-0059.

**Number of Aides Reported for 2004**

Facility Name_____ Contact Person_____ Facility Phone:_____

_____ State License #_____

Address                          City                    State          Zip(Facility ID #)

**To comply with Federal Regulations 42 C.F.R. 483.156(b)(3), the Bureau of Health Facilities, Health Occupations Credentialing is required to determine whether certified nurse aides, home health aides, medication aides have had a lapse of employment of more than 24 consecutive months. Nursing facilities, long term care units in hospitals, intermediate personal care homes, assisted living facilities, residential health care facilities, and home health agencies must provide employment verification for each certified nurse aide, home health aide, medication aide employed for at least 8 hours during the following twelve month period - JANUARY 1, 2004 - DECEMBER 31, 2004.**

**Complete ALL requested information. Incomplete forms will be returned. MUST BE LEGIBLE or form will be returned.**

Certified Nurse Aide / Home Health Aide / Medication Aide Employment Verification

Aide ID No._____ Social Security No._____ Birthdate_____

Name _____

Current Address _____ Zip Code _____

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Aide ID No._____ Social Security No._____ Birthdate_____

Name _____

Current Address _____ Zip Code _____

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No._____ Social Security No._____ Birthdate_____

Name _____

Current Address _____ Zip Code _____

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No._____ Social Security No._____ Birthdate_____

Name _____

Current Address _____ Zip Code _____

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No._____ Social Security No._____ Birthdate_____

Name _____

Current Address _____ Zip Code _____

Return to:       Health Occupations Credentialing;
1000 SW Jackson, Suite 200
Topeka, Kansas 66612-1365
Phone: (785) 296-0059

12/01            THIS FORM MAY BE COPIED IF ADDITIONAL SPACE IS NEEDED            (OVER)

Certified Nurse Aide / Home Health Aide / Medication Aide Employment Verification

Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code

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Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Aide ID No.               Social Security No.                    Birthdate

Name

Current Address                                              Zip Code